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The "Mad Protocol Syndrome." 1. A Case of Type 2 Diabetes Mellitus: Rigid Glucocentrism

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Abstract

The "Mad Protocol Syndrome" is a condition in physicians who rigidly or normatively apply clinical guidelines or protocols. This syndrome, understudied but widespread, is seriously dangerous because it generates iatrogenic effects, promotes polypharmacy and drug interactions, is frequently based on controversial, unsound, and rapidly changing foundations due to the rapid emergence of new studies, fails to consider patient-centered care, is not developed collaboratively by medical specialties and patients, is often influenced by powerful interest groups (such as the relationship of almost all panelists on clinical guideline development committees with the pharmaceutical industry), always maintains an exclusively biomedical perspective ignoring broader biopsychosocial viewpoints, and because there are hundreds or thousands (or perhaps millions?) of clinical guidelines that contradict each other in their recommendations. The patient is a biographical, social, and spiritual reality, never an isolated analytical value. No laboratory target (HbA1c, LDL, or blood pressure) justifies destroying a human being's autonomy, lucidity, or daily well-being. "The Mad Protocol Syndrome" ultimately represents the dehumanization of medicine through bureaucracy. To break this absurd cycle of over-prescription and alienation, 21st-century medicine doesn't need to generate more guidelines from distant experts, but rather urgently reclaim the sovereignty of clinical judgment, safe deprescribing tools, and critical methodological approaches that return control to the primary care physician and dignity to the patient. Studying and reflecting on these concepts is the first step toward transforming clinical practice and rescuing the humane, critical, and sensitive medicine that patients so desperately need. Here is an example of clinical guidelines and protocols for Type 2 Diabetes Mellitus (rigid glucocentrism).

Keywords: Guidelines; Methodology; Applicability, Evidence-based medicine; Patient-centered; Personalized medicine, General practice

Introduction

Clinical practice guidelines provide evidence-based recommendations to optimize patient care, while protocols dictate rigid, step-by-step procedures. In general medicine, these tools are designed to reduce practice variation and translate complex scientific research into actionable, patient-specific encounters (1, 2). However, clinical guidelines face significant systemic challenges. Key problems include a one-size-fits-all approach that fails to account for

individual variations, a lack of universal applicability, and potential conflicts of interest. Misuse of guidelines can sometimes lead to suboptimal care (3-5).

The concept we describe as the “Mad Protocol Syndrome” perfectly defines the phenomenon of the tyranny of clinical guidelines or normative biomedical reductionism. This refers to the growing concern that modern medicine focuses too rigidly on treating isolated biological pathways and rigid, one-size-fits-all algorithms. This severely limits personalized care and ignores the complex, multifaceted realities of human illness (6).

In the scientific and critical medical literature, promoted by movements such as Choosing Wisely, evidence-based medicine without conflicts of interest, and quaternary prevention (7-10), there are blatant examples of guidelines that exhibit these characteristics: medicalization of risk factors, rigid objectives that induce massive polypharmacy in patients with multiple pathologies, a high rate of panelists with conflicts of interest with the pharmaceutical industry, and a complete disconnection from the biopsychosocial model. Below is an example of clinical guidelines and protocols for Type 2 Diabetes Mellitus (rigid glucocentrism).

CLINICAL CASE: The "Mad Protocol Syndrome" applied to Type 2 Diabetes Mellitus (Rigid glucocentrism)

Michael, 78 years old, has the following medical history: Type 2 Diabetes Mellitus (20 years duration), hypertension, chronic ischemic heart disease (previous myocardial infarction 5 years ago), and stage 3a chronic kidney disease. Social situation: He lives alone, with a limited family support network.

The "Mad Protocol" Approach (Rigid Glucocentrism)

Michael attends his routine medical check-up. His latest blood test shows an HbA1c of 7.8%. The doctor, rigidly following traditional clinical guidelines that require a universal target of HbA1c < 7.0% to "reduce cardiovascular risk," decides to intensify treatment without considering the patient's life history or comorbidities.

Michael was already taking Metformin (1000 mg/day) and Empagliflozin (10 mg/day). To force a decrease in his HbA1c percentage, the doctor strictly applied the stepped protocol: He added a Sulfonylurea (Gliclazide 60 mg/day) to stimulate insulin secretion. Months later, seeing that his HbA1c was at 7.2% (close to, but not at, the target), he added basal nighttime insulin (12 units).

Two weeks after starting insulin, Michael suffered severe nocturnal hypoglycemia (blood glucose of 38 mg/dL) while sleeping. He woke up confused, sweaty, and disoriented. When he tried to get out of bed to find food, he fainted, fell, and fractured his hip. During his hospital stay for the fracture, Michael suffered an acute coronary event (unstable angina), triggered by the adrenergic stress of the severe hypoglycemia.

DISCUSSION

Traditional guidelines focused on strict control of glycated hemoglobin (HbA1c < 6.5% or 7%), applied universally and monolithically, promote iatrogenic effects and polypharmacy. Forcing strict glycemic control in elderly patients or those with comorbidities necessitates the successive addition of medications (metformin, sulfonylureas, SGLT2 inhibitors, GLP-1 analogues, and insulin), drastically increasing the risk of severe hypoglycemia and adverse cardiovascular events.

The underlying principles are controversial and evolving: The landmark ACCORD clinical trial had to be prematurely stopped in its intensive treatment arm due to increased mortality in the group with stricter glycemic targets (11).

Furthermore, there are conflicts of interest: The committees of the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD) have historically maintained extensive financial and consulting relationships with pharmaceutical corporations that produce the new and expensive families of antidiabetic drugs (12).

In Michael's case, the doctor suffers from the "Mad Protocol Syndrome." From a purely biomedical perspective, the doctor treated a "number" (HbA1c of 7.8%) instead of treating a 78-year-old person with frailty, a risk of falls, and an already damaged heart. It was overlooked that in elderly patients with multiple comorbidities, aggressively lowering glucose increases overall mortality. The protocol encourages the cumulative use of multiple drug classes (polypharmacy), favoring prescription thresholds dictated by industry-linked committees, rather than prioritizing patient safety.

What would be the alternative medical approach for Michael's case? This alternative model focuses on narrative-based medicine, patient safety, and current deprescribing recommendations. A paradigm shift occurs: From Blood Glucose to the Patient. Michael (78 years old) comes to the clinic with an HbA1c of 7.8%. Instead of applying a blinded algorithm, the physician assesses the individual. He applies the criteria from frailty-adapted guidelines (such as the American Geriatrics Society criteria or the GDPS Network criteria), which state that for elderly, frail patient with a history of cardiovascular disease, an HbA1c target between 7.5% and 8.5% is safe, optimal, and realistic (13, 14).

What would a Patient-Centered Intervention Plan look like?

1. Agree on the Clinical Goal
The physician explains to Michael that having "slightly higher" blood glucose is a protective strategy. The real danger at his age is not the 20-year complications (such as retinopathy), but a drastic drop in blood sugar (hypoglycemia) that could cause a heart attack or a fall. It is agreed to maintain HbA1c around 7.8%–8.0%.

2. Optimization and Safe Deprescribing
Instead of adding medications, treatment is simplified to avoid polypharmacy and kidney damage: Metformin is continued, but the dose is adjusted (e.g., 850 mg/day) with close monitoring of his kidney function (stage 3a renal impairment). Empagliflozin is continued due to its proven benefit in heart failure and kidney protection, provided the patient does not have dehydration or recurrent urinary tract infections. Secretagogues and Insulin are prohibited: Sulfonylureas and basal insulin are strictly ruled out. They do not provide a net benefit in this patient profile and increase the risk of death from hypoglycemia.

3. Biopsychosocial Approach and Social Support
The doctor notes that Michael lives alone and has a limited support network. Therefore, a Social Intervention is indicated: A consultation is arranged with the social worker at the health center to assess the need for home care and ensure proper medication adherence without errors. Self-Care Education: Simple guidelines for diet and physical activity, adapted to his heart condition, are established, prioritizing strength exercises to prevent sarcopenia and falls.

One year later, Michael maintains a stable HbA1c of 7.9%. He has not experienced any episodes of hypoglycemia. His kidney function remains stable, and he walks daily in his neighborhood without dizziness. By avoiding polypharmacy, unnecessary pharmaceutical expenses are reduced, his cardiovascular health is protected, and his autonomy and functional independence are preserved.

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